b. A verification of a recipient's appropriateness of placement and/or services; and (7-1-94)

c. Conduct complaint investigations at the Department's request. (7-1-94)

181. -- 184. (RESERVED).

185. MEDICAL CARE ADVISORY COMMITTEE. The Director of the Department will appoint a Medical Care Advisory Committee to advise and counsel on all aspects of health and medical services. (11-10-81)

01. Membership. The Medical Care Advisory Committee will include, but not be limited to, the following: (11-10-81)

a. Licensed physicians and other representatives of the health professions who are familiar with the medical needs of low-income population groups and with the resources available and required for their care; and (11-10-81)

b. Members of consumer groups, including MA recipients and consumer organizations. (11-10-81)

02. Organization. The Medical Care Advisory Committee will:

a. Consist of not more than twenty-two (22) members; and (11-10-81)

b. Be appointed by the Director to the Medical Care Advisory Committee to serve three (3) year terms, whose terms are to overlap; and (11-10-81)

c. Elect a chairman and a vice chairman to serve a two (2) year term; and (11-10-81)

d. Meet at least quarterly; and (11-10-81)

e. Submit a report of its activities and recommendations to the Director at least once each year. (11-10-81)

03. Policy Function. The Medical Care Advisory Committee must be given opportunity to participate in MA policy development and program administration. (11-10-81)

04. Staff Assistance. The Medical Care Advisory Committee must be provided staff assistance from within the Department and independent technical assistance as needed to enable them to make effective recommendations, and will be provided with travel and per diem costs, where necessary. (11-10-81)

186. -- 189. (RESERVED).

190. PROGRAM INTEGRITY. (11-6-93)

01. Purpose. This section is intended to protect the integrity of the state plan by identifying instances of fraud, abuse, over-utilization and other misconduct by providers and their employees, and recipients, and by providing that appropriate action be taken to correct the problem. Action will be taken to protect both program recipients and the financial resources of the plan. Where minimum federal requirements are exceeded, it is the Department's intent to provide additional protections. Nothing contained herein shall be construed to limit the Department from taking any other action authorized by law, including, but not limited to, seeking damages under Idaho Code section 56-227B. (11-6-93)

02. Authority. (11-6-93)

a. 42 C.F.R., Part 455, requires states to identify, investigate and refer suspected cases of fraud and abuse. (11-6-93)

b. 42 C.F.R., Part 1002, requires states to adopt procedures which enable it to exclude a person for any reason for which the secretary of HHS could exclude such person. Additionally, it authorizes states to identify its own reasons and periods for imposing sanctions. (11-6-93)

c. Idaho Code, 15-134 authorizes the director to deny, suspend, or revoke provider status, and to impose monetary penalties against certain providers in specific instances. (11-6-93)

d. 42 C.F.R., Part 456, requires states to implement programs to safeguard against unnecessary or inappropriate use of services, excessive payments, and to assure the quality of services. (11-6-93)

e. 42 C.F.R., Part 433, imposes requirements on states to collect overpayments made to providers. (11-6-93)

f. Idaho Code, 56-202(b) and 56-135 require the Department to promulgate, adopt and enforce rules and regulations and methods of administration to carry out the purposes of the state plan. (11-6-93)

g. Idaho Code, 56-227(e) requires the Department to establish and operate a fraud control program to monitor public assistance programs. (11-6-93)

h. 42 C.F.R. section 431.54(e) authorizes states to restrict recipients to designated providers when the recipients have utilized services at a frequency or amount that is not medically necessary, or in accordance with utilization guidelines established by the state. (11-6-93)

03. Definitions. For purposes of this section, unless the context clearly requires otherwise, the following words and terms shall have the following meanings: (11-6-93)

a. Abuse. Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program. (11-6-93)

b. Claim. An application submitted by a person to the Department, or an agent thereof, for payment of an item or service under the state plan for medical assistance, including, but not limited to, those forms identified in Subsection 03.09003.10. of this chapter. (11-6-93)

c. Exclusion. A specific provider will be precluded from providing services and receiving reimbursement under Medicaid. (11-6-93)

d. False claim. Any incorrect claim for items or services, including any misstatement or misrepresentation of a material fact on a cost report, without regard to the intent of the maker. This includes, but is not limited to, reporting costs as allowable which were disallowed in previous audits, unless clearly noted. (11-6-93)

e. Fraud or Fraudulent. An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law. (11-6-93)

f. Item or Service. Includes (a) any item, device, medical supply or service claimed to have been provided to a patient and listed in an itemized claim for program payment or a request for payment, and (b) in the case

of a claim based on costs, any entry or omission in a cost report, books of account or other documents supporting the claim. (11-6-93)

g. Medical Assistance. Shall mean payments for part or all of the cost of such care and services allowable within the scope of title XIX of the federal social security act as amended as may be designated by Department rules. (11-6-93)

h. Owner. A person having 5% or more interest in the facility or provider organization. (11-6-93)

i. Person. An individual, trust or estate, partnership, corporation, professional association or corporation, or other entity, public or private. (11-6-93)

j. PRO. Any peer review organization. (11-6-93)

k. Program. The Medicaid Program or any part thereof, including Idaho's state plan. (11-6-93)

l. Recoup and Recoupment. That payment of provider claims will be withheld for the purpose of recovering funds which have been paid for items or services the Department has subsequently determined should not have been paid. (11-6-93)

m. Sanction. Any abatement or corrective action taken by the Department which is appealable under subsection 190.05. of this section. (11-6-93)

n. State plan. The Medicaid program as it exists in Idaho. (11-6-93)

o. Suspension. The temporary barring of a person from participation in the Medicaid program pending further or additional action. (11-6-93)

04. Methodology. The Department will identify potential instances of fraud, abuse, over-utilization and other misconduct by any person related to involvement in the program. Methods may include, but are not limited to, review of computerized reports, referrals from other agencies, health care providers or persons, or conducting audits. Reviews may occur on either prepayment or postpayment basis. (11-6-93)

a. Surveillance and Utilization Review (S/UR) Committee. Instances of suspected fraud, abuse, over-utilization and other misconduct may be referred to a review committee organized by the Department. The committee shall be chaired by the Director's designee, and shall consist of health professionals and other staff nominated to and accepted by the committee. The committee may also consult with other professionals as necessary. The function of the committee will be to review recommendations concerning corrective action. (11-6-93)

b. Corrective Action. When an instance of fraud, abuse, over-utilization or other misconduct is identified, the Department will take action to correct the problem as provided in this section. Such action may include, but is not limited to, exclusion, suspension, recoupment, denial of payment, imposition of civil monetary penalties, termination of provider agreement, provider lock-in, and referral for prosecution and/or to state licensing boards. (11-6-93)

05. Provider Review. (11-6-93)

a. Denial of Payment and Recoupment. The Department shall refuse to pay any and all claims it determines are for items or services: (11-6-93)

i. Not provided or not medically necessary; (11-6-93)

ii. Not documented to be provided or medically necessary; (11-6-93)

iii. Not provided in accordance with professionally recognized standards of health care; (11-6-93)

iv. Not covered by the state plan; or (11-6-93)

v. Provided contrary to the Rules Governing Medical Assistance, the Provider Reimbursement manual, or the provider agreement. If payment has been made, the Department shall recoup the amount paid for these items or services. If recoupment is impracticable, the Department may pursue any available legal remedies it may have. (11-6-93)

b. Mandatory Exclusions. The Department shall exclude any person that: (11-6-93)

i. Has committed a criminal offense related to the delivery of an item or service under Medicare or any State health care program, including the performance of management or administrative services relating to the delivery or items or services under any such program; (11-6-93)

ii. Has been convicted, under Federal or State law, of a criminal offense related to the neglect or abuse of a patient, in connection with the delivery of a health care item or service, including any offense that the Department concludes entailed, or resulted in, neglect or abuse of patients. The conviction need not relate to a patient who is a program beneficiary; or (11-6-93)

iii. Is identified by HCFA as having been excluded by another state or the Office of Inspector General or any person HCFA directs the Department to exclude. No mandatory exclusion imposed pursuant to paragraphs i or ii, will be for less than 10 years. The exclusion may exceed 10 years if aggravating factors are present. For purposes of paragraph i, a person has committed a criminal offense if he/she has committed an act defined as a criminal offense under any federal, state or local law, whether or not he/she has been convicted of said offense in a criminal proceeding. (11-6-93)

c. Permissive Exclusions. The Department may exclude any person: (11-6-93)

i. That has had action taken against them by a state licensing board, including, but not limited to suspension, in which case, the period of the exclusion shall not be less than the period of suspension by the licensing board; (11-6-93)

ii. That has been identified by a peer review group or organization as endangering the health and/or safety of a patient; (11-6-93)

iii. That has failed or refused to disclose or make available to the Department, or its authorized agent, or any licensing board, any records maintained by the provider or required of the provider to be maintained the Department deems relevant to determining the appropriateness of payment except for records priviledged under Idaho Code Section 39-1392b;or (11-6-93)

iv. For any reason for which the Secretary of Health and Human Services, or his designee, could exclude under parts 1001 or 1003, 42 C.F.R. Permissive exclusions will be for a period of 5 years, unless aggravating or mitigating factors form a basis for lengthening or shortening that period. (11-6-93)

d. Aggravating and Mitigating factors. For purposes of lengthening the period of mandatory exclusions and lengthening or shortening the period of permissive exclusions, the following factors will be considered: (11-6-93)

i. Aggravating Factors. (11-6-93)

(a) The acts resulting in the conviction, or similar acts, resulted in financial loss to the program of $1,500 or more. (The entire amount of financial loss to such program will be considered, including any amounts resulting from similar acts not adjudicated, regardless of whether full or partial restitution has been made to the programs); (11-6-93)

(b) The acts that resulted in the conviction, or similar acts, were committed over a period of one year or more; (11-6-93)

(c) The acts that resulted in the conviction, or similar acts, had a significant adverse physical, mental or financial impact on one or more program recipients or other individuals; (11-6-93)

(d) Any sentence imposed by the court related to the same act; (11-6-93)

(e) The excluded person has a prior criminal, civil or administrative sanction record; or (11-6-93)

(f) The person has at any time been overpaid a total of $1,500 or more by Medicare or State health care programs as a result of improper billings. (11-6-93)

ii. Mitigating Factors. (11-6-93)

(a) The person committed a misdemeanor offense, or the entire amount of financial loss to Medicare and the State health care programs due to the acts that resulted in the conviction, and similar acts, is less than $1,500; (11-6-93)

(b) The record demonstrates that the person had a mental, emotional or physical condition before or during the commission of the offense that reduced the individual's culpability (the fact that such a condition existed does not necessarily reduce the individual's culpability); or (11-6-93)

(c) The person's cooperation with Federal or State officials resulted in administrative sanctions or criminal charges being filed against other persons. (11-6-93)

e. Civil Monetary Penalties. The Department may assess, in lieu of exclusion, or in addition thereto, monetary penalties of a civil nature against any provider, facility, owner, officer, director or managing employee, who: (11-6-93)

i. Fails or refuses to comply with the rules and regulations governing medical assistance; (11-6-93)

ii. Knowingly, or with reason to know, makes a false statement of a material fact in any record required to be filed under the state plan; each false statement shall be considered a separate violation, even if included in the same submission; (11-6-93)

iii. Refuses to allow representatives or agents of the Department to inspect any record, book, or file maintained by the provider or required of the provider to be maintained which, in the Department's judgment, is necessary to determine appropriateness of payments; (11-6-93)

iv. Wilfully prevents, interferes with or attempts to impede in any way the work of any duly authorized representative or agent of the Department; or (11-6-93)

v. Wilfully destroys any evidence of any violation of the rules governing medical assistance. Assessments shall be $1000 per violation unless reduced by mitigating factors. Mitigating factors may include, but are not limited to, the nature and circumstances of the incident, the degree of culpa-

bility, lack of prior offenses or other wrongful conduct, and the financial condition of the offender. (11-6-93)

f. Miscellaneous Corrective Actions. The Department may take lesser action to investigate, monitor and correct suspected instances of fraud, abuse, over-utilization, and other misconduct, including, but not limited to: (11-6-93)

i. Issuance of a warning letter describing the nature of suspected violations, and requesting an explanation of the problem and/or a warning that additional action may be taken if the action is not justified or discontinued; (11-6-93)

ii. Prepayment review of all or selected claims submitted by the provider with notice that claims failing to meet written guidelines will be denied; (11-6-93)

iii. Referral to state licensing boards for review of quality of care and professional and ethical conduct; or (11-6-93)

iv. Termination of provider agreements. (11-6-93)

g. Immediate Action. (11-6-93)

i. Suspension of payments pending investigation. In the event the Department identifies a suspected case of fraud, abuse, over-utilization, or other misconduct which requires further investigation, and determines that a substantial possibility exists that payments made during the investigation will be difficult or impractical to recover, the Department may suspend or withhold payments on any pending or subsequent claims while the provider continues to participate in the program. (11-6-93)

ii. Interim Suspension. In the event the Department identifies a suspected case of fraud, abuse, over-utilization, or other misconduct, the Department may summarily suspend a provider or employee of a provider if it determines that it is necessary to prevent or avoid immediate danger to the public health, safety, or welfare. Such a finding will be incorporated in the order. The provider shall be given notice but the order is effective when issued. (11-6-93)

iii. Appeal of Immediate Action. Whenever action is taken under Subsection 190.01.g., a hearing will be held within 30 days of receipt of any duly filed notice of appeal, if any appeal is made. (11-6-93)

h. Disclosure of Certain Persons. Prior to entering into or renewing a provider agreement, or at any time upon written request by the Department, a provider must disclose to the Department the identity of any person described at 42 C.F.R . 1001.1001. The Department may refuse to enter into or renew an agreement with any provider associated with any person so described. The Department may also refuse to enter into, or terminate, a provider agreement if it determines that the provider did not fully and accurately make any disclosure required under this subsection. (11-6-93)

i. Notification of Exclusions. (11-6-93)

i. Provider Notification. When the Department determines exclusion is appropriate, it will send written notice of the decision to the person so excluded. The notice will state the basis for the exclusion, the length of the exclusion, the effect of the exclusion on that person's ability to provide services under state and federal programs, and the person's appeal rights. (11-6-93)

ii. Notice to State Licensing Authorities. The Department will promptly notify all appropriate licensing authorities having responsibility for licensing or certification of a person excluded from participation of the

facts and circumstances of the exclusion. The Department may request certain action be taken and that the Department be informed of actions taken. (11-6-93)

iii. Public Notice. The Department will give notice of the exclusion and the effective date to the public, appropriate beneficiaries, and may give notice as appropriate, including, but not limited to, related providers, the PRO, institutional providers, professional organizations, contractors, other health insurance payors, and other agencies or Departmental divisions. (11-6-93)

iv. Department of Health and Human Services. The Department shall notify the OIG within 15 days after it learns a person has been convicted of a criminal offense related to participation in the delivery of health care items or services under the program. (11-6-93)

j. Appeals. Any exclusion, suspension, recoupment, denial of payment, civil monetary penalty, or termination of provider agreement for cause, may be appealed as a contested case pursuant to the Rules and Regulations Governing Contested Cases, IDAPA 16, Title 05, Chapter 03. Unless action is taken pursuant to subsection g of this section, an appeal stays the action until the time to appeal the Department's final order has expired. (11-6-93)

06. Recipient Utilization Control Program. (11-6-93)

a. Purpose. The Recipient Utilization Control program is designed to promote improved and cost efficient medical management of essential health care by monitoring recipient activities and taking action to correct abuses. (11-6-93)

b. "Lock-in" Defined. "Lock-in" is the process of restricting the access of a recipient to a specific provider or providers. (11-6-93)

c. Criteria for Lock-in. (11-6-93)

i. The Department shall review recipients to determine if services are being utilized at a frequency or amount that results in a level of utilization or a pattern of services which is not medically necessary. Evaluation of utilization patterns can include, but is not limited to, review by the Department staff of medical records and/or computerized reports generated by the Department reflecting claims submitted for physician visits, drugs/prescriptions, outpatient and emergency room visits, lab and/or diagnostic procedures, hospital admissions, and referrals. (11-6-93)

ii. Recipients demonstrating unreasonable patterns of utilization and/or exceeding reasonable levels of utilization shall be reviewed for restriction. (11-6-93)

iii. Since it is impossible to identify all possible patterns of over-utilization, and since a particular pattern may be justified based on individual conditions, no specific criteria for lock-in will be developed. However, the S/UR Committee may develop guidelines for purposes of uniformity. The guidelines will not be binding on the Department and will not limit or restrict the ability of the Department to impose lock-in when any pattern of over-utilization is identified. (11-6-93)

d. Notification and Procedures of Lock-in. (11-6-93)

i. A recipient who has been designated by the S/UR Committee for the Recipient Utilization Control Program will be contacted by the Regional Programs Manager or designee. (11-6-93)

ii. The recipient shall have the opportunity to select designated provider(s) in each area of misuse and so specify on the Utilization Control Agreement form. (11-6-93)

iii. The Department shall not implement the continued recipient restriction if a valid appeal is noted pursuant to subsection f. (11-6-93)

iv. The Department shall restrict recipients to their designated providers for a time period determined by the S/UR committee. Upon review at the end of that period, lock-in may be extended for an additional period determined by the S/UR committee. (11-6-93)

v. Payment to provider(s) other than those specified on the Utilization Control Agreement form is limited to: Documented emergencies; or written referrals from the primary physician as designated on the Utilization Control Agreement form. (11-6-93)

vi. During the initial interview with the Regional Programs Manager or his designee, the recipient will be given written notification of the Department's decision to place the recipient on the Recipient Utilization Control Program which will: (11-6-93)

(a) Clearly describe the recipient's appeal rights in accordance with the provisions subsection f; (11-6-93)

(b) Specify the primary physician and the effective date of the restriction; (11-6-93)

(c) Verify the recipient's choice of provider(s); and (11-6-93)

(d) Provide the original or a copy of the Utilization Control Agreement form to the recipient. (11-6-93)

vii. Upon return of the notification from the Regional Programs Manager or their designee, the Department will contact the provider(s) selected to assure the provider is willing to provide the service. (11-6-93)

viii. Following confirmation from the provider, the medical restriction will become effective on the first day of the following month when the MA eligibility card is issued with the restrictions noted. (11-6-93)

e. Penalties for Noncompliance. (11-6-93)

i. If a recipient fails to respond to the regional notification of medical restriction(s), fails to sign the Utilization Control Agreement form, or select a primary physician within the specified time period, the Medicaid benefits will be restricted to documented emergencies only. (11-6-93)

ii. If a recipient continues to abuse and/or over-utilize items or services after being identified for lock-in, the Department may terminate medical assistance benefits for a specified period of time as determined by the Department. (11-6-93)

f. Appeal of Lock-in. Department determinations to Lock-in a recipient may be appealed in accordance with the fair hearings provisions of the Department's "Rules Governing Contested Cases and Declaratory Rulings," IDAPA 16, Title 05, Chapter 03. (11-6-93)

07. Recipient Explanation of Medicaid Benefits (REOMBs). (11-6-93)

a. The Department will conduct monthly surveys of services rendered to MA recipients using REOMBs. (11-10-81)

b. A MA recipient is required to respond to the Department's explanation of medical benefits survey whenever he is aware of discrepancies. (11-10-81)